Welcome To Gerou Chiropractic Office

Date: _______________
Patient #: ____________ **"Preferred Name":** ________________

Last Name: _______________ **Full First Name**: _______________ **Middle Initial**: ___
Address: ______________________ **Telephone**: Home #: ________________
City: ___________________ Cell #: ________________
State: ________________ Work #: ________________
Zip: _____________ Is it okay to contact you at work? [ ]yes [ ]no.
Birthdate: ____________ **Age**: _____ **Sex:** Male / Female
Social Security #: ____________________
E-mail address: ______________________
Employer: ___________________ **Occupation:** ___________________________
Marital Status: ____________ **Spouse's Name:** ________ **Children:** ______________
How Did You Find Our Office: [ ] **Referred By**: ______________
[ ] Yellow Pages Ad - (SBC or Yellow Book?)
[ ] Location or Sign
[ ] Advertising-(where: _____________)

Is There A Chance That You Are Pregnant: [ ]yes [ ]no

Do You Have Insurance: [ ]yes [ ]no (If YES, please present card to front desk)
Is Your Condition Due To A Work Injury: [ ]yes [ ]no
Is Your Condition Due To An Auto Accident: [ ]yes [ ]no
Are You Filing A Claim: [ ]yes [ ]no

Financial Responsibility/Assignment/Release of Information:

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

I hereby instruct and direct my insurance co. to pay to this office the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

I authorize this clinic to release any information pertinent to my case to any insurance co., adjustor, and attorney involved in this case, and hereby release this clinic of any consequences thereof.

_______________________________ ____________
Patient Signature Date

_______________________________ ____________
Guardian/Parent Signature Authorizing Care Date